Uniform Medical Plan
Your health. Your plan. Your choice.

Volume 4, Issue 2 **Provider Bulletin** August 2002

Please circulate the *UMP Provider Bulletin* to the appropriate clinical, billing, and bookkeeping staff.

A Personal Note from Andrew Brunskill, M.D., Medical Director

Idaho Medical Director now aboard!

As we have a small population of enrollees who require our services in Idaho, I am delighted to announce that we have brought aboard an Idaho physician as the newest addition to our Medical Director staff. Allen M. Ernster, M.D., is highly familiar with the more rural communities' standard of care as a busy family physician in Lewiston, Idaho. He will also be involved in the development of our disease management programs. Please see page 2 for a personal message from him.

Before closing, I'd like to tell you about the good information available on the Washington State Department of Health's Web site (*www.doh.wa.gov/PatientSafety)* regarding how to avoid medication errors, as well as ways for patients to keep track of medication errors and assist providers in improving patient safety.

Sincerely,

Andrew J. Brunskill, M.D.
UMP Medical Director
abru107@hca.wa.gov
Phone (206) 521-2000
Fax (206) 521-2001

Provider Survey Coming in September

Help us improve Uniform Medical Plan (UMP) services to providers. If you are selected to receive our provider survey, let us know what you think. Please complete and return promptly. Survey results and our action plan will be available in the January *Provider Bulletin* and on the UMP Web site. Thank you for participating!

Have You Seen Our Web Site at *www.wa.gov/hca/ump*?

Lots of UMP information is available on the Web site, including current copies of the *Certificate of Coverage* (COC), policy updates, provider billing and administrative manuals, reimbursement information, and other materials relevant to the plan. In addition, your questions and comments can be submitted to us through the Web site. We encourage you to visit the Web site often for up-to-date plan information and to download our publications.

In This Issue

A Personal Message from Al Ernster, M.D., Idaho Medical Director for UMP

As the cost of medical care continues to frustrate patients, insurance plans, and providers, we have the opportunity in the prevention of disease to bring light to an otherwise dark picture. Prevention may be the best resource we have to manage disease and get a handle on escalating health care expenditures.

Our first foray into disease management is the Diabetes Quality Improvement project. We hope this is assisting you in the quality of care you intend to deliver and your interactions with your diabetic patients. We additionally had to decide on our next undertaking. Should it be hypertension, coronary artery disease, congestive heart failure, stroke, cancer? A common theme has surfaced as we considered which program to develop next. That theme is weight management.

Sixty percent of Americans are overweight, with close to 22 percent being obese. David Satcher, our Surgeon General, issued a Call to Action this past winter for all those involved in health care to try to manage this problem of now epidemic proportions. The toll it brings for future expenditures in health care as a harbinger of hypertension, diabetes, coronary artery disease, stroke, cancer, osteoarthritis, and many other diseases is phenomenal.

Over the next year, we plan to develop strategies for addressing this very difficult health issue. Only 20 percent of people with obesity combine diet and exercise in their efforts to lose weight. We are interested in your input on the most effective approaches, so I encourage you to e-mail your ideas to Dr. Brunskill at *abru107@hca.wa.gov*.

For most of you, the use of diet and exercise in the management of disease is old news. We want to support your efforts with the earliest intervention we can produce, the treatment of overweight and obese patients. I look forward to working with you!

Sincerely,

Al Ernster, M.D.

UMP Medical Director, Idaho

To obtain this document in another format, call our Americans with Disabilities Act (ADA) Coordinator at (360) 923-2805. TTY users (deaf, hard of hearing, or speech impaired), call (360) 923-2701 or toll-free 1-888-923-5622.

How To Reach Us

UMP Web site ***www.wa.gov/hca/ump***

Provider Services Lines

Claims Processing and Preauthorizations — **Toll-free 1-800-464-0967**, **Local (425) 670-3046**, **Fax (425) 670-3199**

- Benefits information
- Customer service
- Claims status and information
- Enrollee eligibility information
- General billing questions
- Medical review
- Prenotification/preauthorization
- Status of submitted claim
- Verify provider's preferred status

Automated enrollee eligibility information — **Toll-free 1-800-335-1062**

Have subscriber I.D. number available, and select #2 for "PEBB subscriber information"

Provider Information, Credentialing, and Contracting Issues — **Toll-free 1-800-292-8092**, **Local (206) 521-2023**, **Fax (206) 521-2001**

- Billing manuals and payment policies
- Change of provider status
- Fee schedules
- New provider enrollment
- Preferred provider contract information
- Policies and procedures
- *Provider Bulletin* feedback

Alternáre of Washington Health Services, Inc. — **Toll-free 1-800-500-0997**, **Local (206) 405-2923**

- Preferred network information for licensed massage practitioners, naturopathic physicians, and licensed acupuncturists

Medco Health Solutions — **Toll-free 1-800-903-8224**

- Prescription drugs and claims questions

Free & Clear — **Toll-free 1-800-292-2336**

- Tobacco cessation program information

Notifying the UMP of Changes

As a preferred provider, it is important that you keep us informed of any changes to your practice or status, such as changes to your business address, telephone numbers, tax I.D. number, licensure, certification, registration, or qualifications. See the "How to Reach Us" section above for the telephone and fax numbers to notify the UMP Provider Credentialing staff when changes occur.

UMP Information and Services

Requests and Applications to be in the UMP Preferred Provider Network

Recently, UMP established priorities for adding new providers to the UMP Preferred Provider Network due to the high volume of requests and applications being received, as well as our own limited resources for contracting and credentialing. In prioritizing, UMP is now primarily focusing on the credentialing of new applicants in specialties and geographic areas where our current network is weaker than elsewhere.

When a request or an application is received from a provider for a non-priority area, we are informing the provider that we will not be processing their request for participation at this time. In this situation, applicant information will be retained for future processing when there becomes a need for their specialty in their geographic area.

Please note that UMP is **not** closing its provider network. We are simply focusing our efforts in areas where need is the greatest. Thank you for your understanding.

Electronic Funds Transfers

The UMP is working towards implementation of Electronic Funds Transfer (EFT) capability. EFT is a form of direct deposit that allows the transfer of UMP payments directly to a provider's bank account. Providers are not required to file claims electronically to receive payments through this direct deposit process. Some benefits with the EFT process include:

- Quicker payment
- Elimination of multi-handling risks
- Increased convenience, ensuring timely payment in the bank
- No lost or delayed checks
- Easier bank reconciliation
- Administrative efficiency

The UMP can reduce administrative spending by eliminating the process of issuing paper checks and depositing payments directly into providers' bank accounts. If you are interested in receiving UMP payments via EFT, please let us know by calling 1-800-292-8092 or (206) 521-2023 and asking for Cynthia Ray-Anderson or Cheryl Mustard. You can also reach Cynthia through e-mail at *cray107@hca.wa.gov* or Cheryl at *cmus107@hca.wa.gov*. The UMP plans to begin offering this service later this year if there is enough interest.

UMP Provider E-mail Mailing List Service

We encourage you to subscribe to UMP's electronic mailing list. When UMP makes major benefit or policy changes, updates payment systems, or revises billing manuals, you will receive e-mail notification. It's easy to sign up by visiting the following Web address:

listserv.wa.gov/archives/ump-providers.html

The *UMP Provider Bulletin* and revised pages to our billing manuals will continue to be mailed to you on a periodic basis. However, by joining our electronic mailing list, you will be notified as soon as updates are posted to the UMP Web site, so you will have the quickest possible access to the most current information.

Confirmation of Preferred Provider Status for Referrals to Other Providers

When referring your patient for specialty care, we encourage you to contact us at 1-800-464-0967 or (425) 670-3046 to confirm that you are referring your patient to another UMP preferred provider. When utilizing preferred providers, the UMP reimbursement level is higher and enrollees have lower out-of-pocket costs.

Interactive Voice Response (IVR) System

As a reminder, our Interactive Voice Response (IVR) is available to verify eligibility or claims status from 5 a.m. to 8 p.m. PST. To access this self-service phone program, simply call UMP Customer Service at 1-800-762-6004 or Provider Services at 1-800-464-0967 and select the IVR application. By following the recorded prompts and entering the requested enrollee information, you will be able to verify coverage and/or claims status for multiple enrollees, with no waiting. Furthermore, there are no restrictions as to the number of inquiries per call when using the IVR. If you are calling during Customer Service hours (8 a.m. to 6 p.m., Monday through Friday), you can exit the system at any time during your call and speak to a Customer Service representative.

Physician Available to Discuss UMP Denials Based on Medical Necessity

The UMP Medical Director or Associate Medical Director is available by phone to discuss with you any services or claims that were denied based on issues of medical necessity. If you have such a need, please contact us at (206) 521-2000 to schedule a time with the physician.

Professional Provider Fee Schedule, Payment Policies, and Billing Instructions

The UMP *Professional Provider Fee Schedule* and some payment policies were updated on July 1, 2002. The information that follows provides further details pertaining to the revised maximum allowances and changes to policies.

Note: CPT is a trademark of the American Medical Association. CPT codes and descriptions only are copyright 2001 American Medical Association. All Rights Reserved. Applicable FARS/DFARS Apply.

Maximum Allowances Based on Resource-Based Relative Value Scale (RBRVS) Methodology

The maximum allowances for most codes on the fee schedule are based on:

- The Centers for Medicare & Medicaid Services (CMS) 2002 relative value units (RVUs);
- CMS's 2002 statewide Geographic Practice Cost Indices (GPCIs) for Washington State; and
- The UMP's RBRVS conversion factor, which increased to $47.33.

Site-of-service rate differentials apply to many of the procedure codes based on CMS's dual levels of practice expense RVUs.

The statewide GPCIs used in the calculation of the UMP updated rates are:

- 0.989 (work);
- 1.011 (practice expense); and
- 0.788 (malpractice expense).

The updated UMP conversion factor equates to a 3.92% inflation increase from our modeled 2002- 2003 budget neutral conversion factor. This weighted inflation factor reflects a 3.6% update for non-malpractice RVU costs (approximately 95% of total RVUs) and a 10% update for malpractice RVU costs (approximately 5% of total RVUs).

Maximum Allowances Based on Drugs and Biologicals Payment Policy

The maximum allowances for drugs and biologicals administered in providers' offices are set at 95% of the average wholesale price, following the Medicare payment policy. These rates for the HCPCS drug and biological codes are updated as we receive fee changes from the Medicare Part B Carrier, usually on a quarterly basis.

Payment Policy for Durable Medical Equipment/Prosthetics and Orthotics

Many supply items on the UMP *Professional Provider Fee Schedule* are considered "bundled" into the cost of other services and are not paid separately. Supply codes that are bundled are identified as such on the fee schedule and in the UMP *Provider Billing and Administrative Manual for Professional Providers*. Please see the "Prosthetic and Orthotic Fee Schedule for Suppliers" update in this provider bulletin for more information on the maximum allowances for separately payable items.

Maximum Allowances Based on Medicare's Clinical Diagnostic Laboratory Fee Schedule

The maximum allowances for clinical laboratory procedure codes (with the exception of Pap smears) are equal to 136.5% of Medicare's 2002 *Clinical Diagnostic Laboratory Fee Schedule*. While there were a few changes to rates, most of the UMP maximum allowances for clinical laboratory procedure codes did not change with this update as a result of a provision of the Balanced Budget Act of 1997 that provided no inflationary update to Medicare's rates this year. The UMP maximum allowance for the conventional Pap smear codes is $14.60; the maximum allowance for thin layer preparation Pap smear codes is $25.00.

Additions to Bundled Services and Supplies

For the past four years, we have gradually been phasing out separate payment for the surgical tray HCPCS code A4550 and supply HCPCS codes A4263, A4300, and G0025, as CMS was transitioning the costs for these into the resource-based practice expense RVUs for the applicable procedure(s). For dates of service on or after July 1, 2002, the UMP no longer reimburses for the surgical trays or the specified supplies separately, which is consistent with Medicare's current payment policy. Payment of these surgical trays and supplies is considered bundled into the full resource-based practice expense component of the total RBRVS payment for the procedure.

Separate Facility Reimbursement and Ambulatory Surgery Center Criteria

Facility charges for services in physician offices, including surgical suites, are generally not separately reimbursed, as these expenses are factored into the practice expense component of the non-facility setting maximum allowance paid by the UMP for the professional service. As a result, the UMP will not reimburse surgical facility charges separately in an outpatient

setting, unless the facility is a hospital, birthing center (preauthorized by the UMP), or Ambulatory Surgery Center (ASC). The ASC facilities must meet the following UMP criteria for coverage/reimbursement consideration:

1. Must be licensed by the state(s) in which it operates, unless that state does not require licensure.
2. Must have at least one of the following credentials:
   a. Medicare Certification as an ASC; or
   b. Accreditation as an ASC by a national accrediting organization recognized by CMS – see list below for organizations that have been granted deemed status.
      - Accreditation Association for Ambulatory Health Care (AAAHC) – *www.aaahc.org*
      - American Association for Accreditation of Ambulatory Surgery Facilities, Inc. (AAASF) – *www.aaaasf.org*
      - Joint Commission on Accreditation of Healthcare Organizations (JCAHO) – *www.jcaho.org*

Please note that the appropriate procedure code modifier to indicate facility charges on an ASC claim is "SG." The state-assigned modifier "1M" is no longer valid for UMP payment consideration.

For information on becoming a Medicare-certified ASC, refer to the CMS Web site at *www.hcfa.gov/medicare/enrollment/enroll.htm* or contact the Department of Health, Office of Health Care Survey, Facilities and Services Licensing, at (360) 705-6612.

Anesthesia Reimbursement System

On July 1, 2002, the UMP payment system for anesthesia services was updated. Reimbursement continues to be composed of base units plus anesthesia minutes. The UMP anesthesia conversion factor for the 15-minute-based system increased to $43.20 and the 2002 anesthesia base units were incorporated. The revised anesthesia conversion factor reflects an inflation adjustment of 3.6%.

Providers are required to report the actual anesthesia minutes in the unit field (24G) on the HCFA-1500 claim form for payment purposes. Actual payment will continue to be calculated on a per-minute basis.

For the majority of the CPT anesthesia codes, the current anesthesia bases in the UMP payment system are the same as CMS's 2002 anesthesia base units and the American Society of Anesthesiologists' (ASA) 2002 anesthesia base units. For the CPT anesthesia codes where CMS and the ASA bases were different, the UMP decided to use CMS's anesthesia base with a few exceptions based on feedback from our State Agency Anesthesia Technical Advisory Group. The updated UMP *Anesthesia Fee Schedule* containing the anesthesia bases being used for reimbursement of anesthesia services is available on the UMP Web site at *www.wa.gov/hca/ump.* If you do not have access to the Web site, we will send a copy of the fee schedule to you upon request.

Prosthetic and Orthotic Fee Schedule, including Ostomy and Urological Supplies for Suppliers

The UMP *Prosthetic and Orthotic Fee Schedule* (including Ostomy and Urological Supplies) for suppliers was updated on July 1, 2002. Most of the maximum allowances are based on Medicare's 2002 Durable Medical Equipment/Prosthetic and Orthotic Fee Schedule, which included a 1% inflation update for prosthetics and orthotics and a 0.6% inflation update for therapeutic shoes. Medicare made no inflationary update to their rates for ostomy and urological supplies this year, as a result of a provision in the Balanced Budget Act of 1997.

Reporting Code Edit Concerns

If you believe we have made an error when a certain procedure is bundled into payment of another reported service, please call UMP Provider Services. Also contact Provider Services if you experience repeated claim denials where there may be a problem with a system edit/update. UMP Provider Services can be reached at 1-800-464-0967 or (425) 670-3046 (Seattle area). You may also correspond with UMP via fax at (425) 670-3199 or by mail at:

Uniform Medical Plan
P.O. Box 34850
Seattle, WA 98124-1850

If you are not satisfied with the response after contacting the claims office, please contact Kathy Fancher at (206) 521-2007 or 1-800-292-8092 for further review and assistance. She can also be reached through e-mail at *kfan107@hca.wa.gov*.

Chiropractor Fee Schedule and Payment Policies

Coverage and Reimbursement Information for Chiropractic Extraspinal Manipulative Treatment (CPT code 98943)

Effective for dates of service on or after June 13, 2002, the UMP reimburses for medically necessary extremity manipulations reported with CPT code 98943. Medically necessary manipulations of the spine or extremities, and office visits to obtain these manipulations, are covered to a combined total of 10 visits per calendar year. The fee schedule maximum allowance is currently $35.50 for extremity manipulations when performed and billed as a stand-alone procedure. For payment consideration when the extremity manipulation is performed during the same visit as a spinal manipulation, CPT 98943 must be submitted on the HCFA 1500 claim form with modifier –51. In this situation, the maximum allowance for CPT code 98943 will be reduced to $17.25, as UMP standard multiple procedure rules are applicable.

Please note: It is inappropriate to report more than one unit in the units field on the claim for any of the chiropractic manipulative treatment CPT codes (98940-98943), unless a second office visit for additional manipulation treatment on the same date of service is medically necessary.

Changes to the Chiropractor Fee Schedule Maximum Allowances (Effective 9/1/02)

The UMP *Chiropractor Fee Schedule* maximum allowances are being updated on September 1, 2002. The revised maximum allowances are based on the RBRVS methodology that is used by the UMP for reimbursement of other provider types. For the past several years, only the manipulation codes have been based on the RBRVS methodology, while the other codes have been based on flat fees from a 1993 Sound Health Fee Schedule.

The CMS 2002 RVUs, 2002 statewide geographic practice cost indices, and the UMP RBRVS conversion factor of $47.33 were used in the formula to determine the September 1, 2002 maximum allowances for the UMP *Chiropractor Fee Schedule*. The UMP maximum allowances for covered evaluation and management (E&M) services are set at 90% of the full RBRVS rates.

Updates to the Chiropractor Fee Schedule Payment Policies (Effective 9/1/02)

With the conversion to the RBRVS methodology for reimbursement, covered services will be subject to applicable RBRVS payment rules, such as the bundling of application of hot/cold packs (CPT code 97010). CPT code 97010 is not separately payable, as CMS redistributed the RVUs for this code across all physical therapy procedure codes several years ago. This policy is applied to all provider types paid under UMP fee schedules based on RBRVS methodology. In addition, the following updated policy will apply to E&M services.

UMP uses the CPT definitions for E&M services for new and established patients. If a provider has treated a patient for any reason within the last three years, the person is considered an established patient. (See CPT for complete code descriptions, definitions, and guidelines.)

Chiropractic physicians may report the first four levels of CPT new patient office visits codes (99201-99204) and the first four levels of CPT established patient office visit codes (99211-99214) for UMP payment consideration.

New Patient E&M Services (99201 - 99204)

The following payment policies apply when chiropractic physicians use new patient E&M office visit codes for the initial visit:

- A new patient E&M office visit code is payable only once within a three-year period.
- Modifier -22 is not payable with E&M codes for chiropractic services.
- New patient E&M office visit codes are payable with manipulation codes **only when all of the following conditions are met:**
  1. The E&M service constitutes a significant separately identifiable service that exceeds the usual pre- and post-service work included in the manipulation visit; and
  2. Modifier -25 is added to the new patient E&M code; and
  3. Supporting documentation describing the service(s) provided is included in the patient's record.

Established Patient E&M Services (99211-99214)

The following payment policies apply when chiropractic physicians use established patient E&M office visit codes:

- An established patient E&M office visit code is not payable on the same day as a new patient E&M office visit code.
- Modifier -22 is not payable with E&M codes for chiropractic services.

- Established patient E&M codes are not payable in addition to manipulation codes for follow-up visits except when all of the following conditions are met:
  1. The E&M service is for the **initial visit** for a **new condition** or **new injury**; and
  2. The E&M service constitutes a significant separately identifiable service that exceeds the usual pre- and post-service work included in the manipulation visit; and
  3. Modifier -25 is added to the E&M code; and
  4. Supporting documentation describing the service(s) provided is included in the patient's record.

When a patient requires re-evaluation for an existing condition or injury, either an established patient E&M CPT code (99211-99214) or a chiropractic manipulation code (98940-98943) is payable. Payment will not be made for both. Modifier -25 is not applicable in this situation.

The UMP *Chiropractor Fee Schedule* (for most commonly billed codes), which includes the updated E&M policy, is available on the UMP Web site at *www.wa.gov/hca/ump*. If you do not have access to the Web site, we will send a copy of the fee schedule to you upon request. The updated UMP *Billing and Administrative Manual for Professional Providers* containing our other payment policies mailed with this bulletin is also available on the Web site.

Hospital Inpatient Reimbursement System

The UMP Reimbursement Division is currently working on a project to recalibrate the UMP's inpatient hospital reimbursement system and to calculate updated payment conversion factors for implementation January 1, 2003.

The methodology used for this year's recalibration project is essentially the same as that used for the last system update in 2001. Cost patterns and weights for different types of inpatient procedures will be developed using:

- Comprehensive Hospital Abstract Reporting System (CHARS)—Department of Health (DOH)
- Medicare Cost Reports—Center for Medicare and Medicaid Services (CMS)
- Charity Care and Bad Debt Report (DOH)
- CMS Wage Index

The results of the recalibration, including conversion factors, updated weights, and Version 18.0 of the All Patient Diagnosis Related Grouper (AP-DRG) will be included in new hospital contracts effective on January 1, 2003.

Hospital Outpatient Prospective Payment System (OPPS)

The UMP implemented an Outpatient Prospective Payment System (OPPS) for hospital outpatient facility charges effective January 1, 2002. In April, the first Outpatient Code Editor (OCE) quarterly update was installed following release of the OCE by the Center for Medicare and Medicaid Services (CMS). Additionally, the UMP implemented revised Ambulatory Payment Classifications (APC) weights to correspond with the CMS weight updates and the addition of a number of new APCs.

The UMP payment system follows most Medicare payment policies including the revised policy on observation services. A hospital may receive a separate APC payment for observation services for patients having diagnoses of chest pain, asthma, or congestive heart failure, **when certain additional criteria are met**. Hospitals must use the new code G0244 for observation services that meet the criteria for separate payment and must submit the claim using bill type 13X. Observation is not separately paid if a surgical procedure or any service that has a status indicator of "T" occurs on the day before or the day that the patient is admitted to observation.

Provider Outreach Team

If you need assistance with claims submission, electronic billing, or general customer service issues, please call (425) 670-3100 to talk with a member of the Provider Outreach Team about scheduling an onsite visit.

Revised Policy for Certified Registered Nurse First Assistant (CRNFA) and Registered Nurse First Assistant (RNFA)

We have updated the UMP payment policy related to registered nurse first assistants (RNFA) and certified registered nurse first assistants (CRNFA) for dates of service on or after July 1, 2002.

Previously, services provided by a RNFA or CRNFA were subject to preauthorization, where a case-by-case coverage decision was made based upon the circumstances. As of July 1, 2002, the UMP will allow coverage of CRNFAs, if an assistant at surgery is presently allowed for the procedure(s) performed based on the RBRVS fee schedule payment indicator. The previous preauthorization requirement is no longer applicable. Services provided by non-certified RNFAs will not be covered by the UMP.

UMP will not reimburse the CRNFA directly in any circumstance. For payment consideration, the services provided by the CRNFA must be submitted on a HCFA 1500 claim form and must include the supervising physician's tax ID number in field 25; the CRNFA's name in field 31; and the supervising physician's name and address in field 33. Modifier AS must be reported with the applicable procedure code on the claim for payment consideration.

The UMP allowed amount for covered procedure(s) provided by the CRNFA are subject to all RBRVS payment rules. The fee schedule maximum allowance is set at 80% of the assistant surgeon allowance on the UMP Professional Provider Fee Schedule.

Example:	Provider Type	Allowed
	Surgeon	$1,000
	Assistant Surgeon	$200
	CRNFA	$160

($1,000 x 20%=$200, $200 x 80%=$160)

As with physician assistants, the UMP does not contract directly with CRNFAs. Payment of claims for the services provided by these provider types at the preferred rate (90%) or nonpreferred rate (60%) is contingent upon the supervising/billing physician's preferred status with UMP.

Billing Instructions, Updates, and Reminders

Updated Sections for *UMP Billing and Administrative Manual for Professional Providers*

Enclosed with this bulletin are updated sections for the UMP *Billing and Administrative Manual for Professional Providers*. Please review the updated pages and insert them into your manuals accordingly.

Electronic Claims Submission

Don't forget: When the UMP is an enrollee's primary insurance, we accept electronic professional and facility claims through many electronic clearinghouses. Please use our **electronic claims payer number—75243**—for the submission of electronic claims. If you have any questions and/or difficulties, please contact UMP Customer Service at 1-800-762-6004 (main number) or 1-800-464-0967 (Provider Services line) for assistance.

Valid Diagnosis Codes Requirement

All claims submitted to the UMP for payment consideration must include a valid ICD-9 code and be coded to the highest level of specificity (i.e., 4th/5th digits where applicable).

Valid Place of Service Codes Requirement

CMS's current 2-digit place-of-service codes must be included on the HCFA-1500 claim form for UMP payment consideration. In many circumstances, there is a payment differentiation based on whether the services are provided in a facility or in an office setting. Refer to the UMP *Billing and Administrative Manual for Professional Providers* for a listing of the place-of-service codes and our site-of-service payment policy.

State-Assigned Local Codes 8949M, 1579M, and 1580M Update

The UMP no longer accepts the following state-assigned local codes for payment consideration as of July 1, 2002. Providers should use the applicable CPT or HCPCS level II procedure codes when reporting these services for payment consideration.

Stat Laboratory fee (per episode)	8949M
Acupuncture Services	1579M and 1580M

Medicare Part B Claim Information for Secondary Payment Consideration

It is not necessary for you (or the enrollee) to submit paper claims and copies of the Part B Explanation of Medicare Benefits (EOMB)/Medicare Summary Notices (MSN) from the Medicare Part B Carrier for Washington State (Noridian Mutual Insurance Company) to the UMP for secondary payment consideration. Noridian electronically passes Medicare Part B claim information directly to the UMP for processing of secondary professional outpatient claims for Medicare-enrolled UMP enrollees.

For secondary payment consideration, the UMP will still need paper copies of the Medicare payment information for the following items: inpatient hospital care, durable medical equipment, and home health and hospice care. These are processed by different Medicare carriers/ intermediaries and are not electronically transmitted to UMP at this time.

If you need additional information or assistance, please contact UMP Customer Service at 1-800-762-6004 (main number) or 1-800-464-0967 (Provider Services line).

Nose Worthy News: An Update on the Treatment of Rhinitis

Approximately 20% of the U.S. population is affected by rhinitis. The estimated annual cost of treating rhinitis is $3 to $4 billion in direct medical and pharmacologic services.[1] Allergic rhinitis accounts for 43% of presenting cases, non-allergic rhinitis 23% of cases and mixed etiology 34% of cases.[2] The most common symptoms of rhinitis regardless of etiology include nasal congestion, sneezing, nasal itching, post-nasal drip, and runny nose.[3]

Treatment options for allergic and non-allergic rhinitis are similar. Choices include nasal antihistamines, nasal corticosteriods, and oral antihistamines, with or without decongestants. In the majority of cases, nasal corticosteroids should be the first line therapy in patients with chronic moderate to severe rhinitis and predominantly nasal symptoms. Comparative clinical trials have shown that nasal corticosteroids are more effective in controlling symptoms than nasal cromolyn,[4] or oral antihistamines.[5,6,7,8,9] Clinical studies have also shown that for the treatment of allergic rhinitis, combination therapy with nasal corticosteroids and oral antihistamines is less effective than nasal corticosteroids alone.

Systemic side effects of nasal corticosteriods are minimal in most adult patients when taught to use the spray device properly. Local side effects are usually manageable and include nasal burning or stinging, epistaxis, sneezing, throat irritation, and drying of the mucous membranes. Side effects of many common oral antihistamines include drowsiness, dry mouth, and headache.

Although nasal corticosteroid therapy is more efficacious and more cost-effective than oral antihistamines or combination therapy, a review of the 2001 UMP claims data showed that more than 31% of nasal steroid users are also using antihistamines. We appreciate your support in considering the clinical evidence and cost-effectiveness when prescribing for patients with allergic rhinitis.

References:

1. Komisar, A., "Nasal obstruction due to benign and malignant neoplasms." *Otolaryngol Clin North Am* 1989; 22:351-365.
2. Welsh, P.W., Stricker, W.E., Chu-Pin, C., *et al.* "Efficacy of beclomethasone nasal solution, flunisolide and cromolyn in relieving symptoms of ragweed allergy." *Mayo Clin Proc* 1987; 62:125-134.
3. Dykewicz, M.S., and Fineman, S., eds., "Diagnosis and Management of Rhinitis: Complete Guidelines of the Joint Task Force on Practice Parameters in Allergy, Asthma and Immunology." (Representing the American College of Allergy, Asthma and Immunology and the Joint Council of Allergy, Asthma and Immunology.) *Ann Allergy Asthma Immunol* 1998; 81:463-518.
4. Storms, W.W., "Treatment of seasonal allergic rhinitis with fluticasone propionate aqueous nasal spray: review of comparator studies." *Allergy* 1995; 50:25-29.
5. Juniper, E.F., Guyatt, G.H., Ferrie, P.J., Griffith, L.E., "First-line treatment of seasonal (ragweed) rhinoconjunctivitis. A randomized management trial comparing a nasal steroid spray and a nonsedating antihistamine." *CMAJ* 1997; 156:1123-1131.
6. Condemi, J., Schulz, R., and Lim, J., "Triamcinolone acetonide aqueous nasal spray versus loratadine in seasonal allergic rhinitis: efficacy and quality of life." *Ann Allergy Asthma Immunol* 2000; 84:533-538.
7. Berlin, J.M., Golden, S.J., Teets, S., *et al.* "Efficacy of a steroid nasal spray compared with an antihistamine nasal spray in the treatment of perennial allergic rhinitis." *J Am Osteopath Assoc* 2000; 100 (7 Suppl):S8-13.
8. Weiner, J.M., Abramson, M.J., and Puy, R.M., "Intranasal corticosteroids versus oral H_1 receptor antagonists in allergic rhinitis: systematic review of randomised controlled trials." BMJ 1998; 317:1624-1629.
9. Nash, D.B., Sullivan, S.D., and Mackowiak, J., "Optimizing quality of care and cost effectiveness in treating allergic rhinitis in a managed care setting." Am J Manag Care 2000; 6 (Suppl 1):S3-S15.